ARC 4897C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to case management services

The Human Services Department hereby amends Chapter 73, "Managed Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 83, "Medicaid Waiver Services," rescinds Chapter 90, "Targeted Case Management," and adopts a new Chapter 90, "Case Management Services," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

This rule making adopts a new Chapter 90 that clarifies the case management service activities received by various populations in the Medicaid program and includes a definition of and references to a core standardized assessment (CSA) as required under the Balancing Incentive Program (BIP). BIP was created as part of the federal Patient Protection and Affordable Care Act. Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Acts, chapter 138, section 142(20). In addition, new Chapter 90 outlines and requires billable activities for fee-for-service members, includes a requirement for provider reporting of minor incidents, and includes the person-centered service planning definition and service requirements. Also, cross-reference citations in other chapters that are affected by this rule making are updated.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on November 6, 2019, as **ARC 4739C**.

The Department received 83 written comments from eight respondents regarding the proposed changes. The following persons and organizations provided written comments: Linda Duffy, Integrated Health Home Program Manager, Child Health Specialty Clinics; Sabra Rosener, J.D., Vice President of Government and External Affairs at UnityPoint Health; Flora A. Schmidt, Executive Director, Iowa Behavioral Health Association; Jane Wollum, Administrator, Johnson County Case Management; Cynthia Pederson, J.D., State Long-Term Care Ombudsman; Melissa Ahrens, Director of Integrated Programs, Community Support Advocates; Sara Hackbart, Health Home Program Manager, Amerigroup; and Shelly Chandler, Executive Officer, Iowa Association of Community Providers.

The comments and corresponding responses from the Department are divided into ten topic areas as follows:

1. Additional clarification needed throughout Chapter 90. Twenty-nine comments were received on this topic.

• Twenty-five comments requested clarification regarding how new Chapter 90 applies to integrated health home (IHH) non-intensive care management (ICM) members.

Department response: The Department has added clarifying statements for each rule. The Department has also added statements clarifying that the requirements for this chapter apply to the IHH populations of habilitation services and the children's mental health waiver, and not to the full IHH population.

• Three comments asked to have additional words defined.

Department response: The words "applicant" and "case management" are now defined in the chapter. The Department has taken the request to define the word "representative" under advisement, but has decided to not add the definition. "Representative" has many meanings depending upon how it is used. Leaving "representative" undefined in this chapter allows the broader meanings to all be acceptable.

• One comment requested use of the term "IHH care coordination" instead of "IHH case management."

Department response: The term has been revised throughout the rule making as requested.

2. Location or method of contact. Seven comments were received on this topic.

• Five comments related to the change in location of the case manager quarterly face-to-face contact and to the restrictions involved in using face-to-face or telephonic contact as the methods of required monthly contact.

Department response: The Department has taken the suggestions under advisement, but has decided to not alter the chapter as suggested. The Department strongly believes that the case manager should have more direct interaction with the member and the guardian or representative to improve the case manager's knowledge of the member's residence in order to better assess and monitor member health, safety, and welfare. Members continue to have a choice in location and method of contact that is made outside of these three required contacts.

• One comment asked the Department to specify under what circumstances the managed care organization (MCO) contact requirements might differ from the requirements in subrule 90.4(1).

Department response: The Department has taken the comment under advisement, but has decided to not alter subrule 90.4(1) as suggested. This subrule was written without specificity to allow the Department future flexibility in MCO contract negotiation.

• One comment requested that the Department reinstate the prior rule language that allowed for broader options of methods of communication between the member and case manager for most contacts.

Department response: The Department has taken the comment under advisement, but has decided to not alter the chapter as suggested. In regard to the quarterly face-to-face contacts and the monthly face-to-face or telephonic contacts, the Department has purposely limited the method of contact in order to increase the case manager's direct contact with the member and the guardian or representative. That increased direct contact should improve the case manager's knowledge of the member's residence in order to better assess and monitor member health, safety, and welfare. Members continue to have a choice in location and method of contact that is made outside of these three required contacts.

3. Core standardized assessments. Two comments were received on this topic. Commenters asked for clarification in regard to whether an MCO will perform the core standardized assessment or whether the MCO has the ability to transfer that responsibility to another entity.

Department response: The Department has revised the definition of "core standardized assessment" in rule 441—90.1(249A) to state that an MCO shall either perform core standardized assessments for MCO-enrolled members or transfer the responsibility to another entity.

4. Targeted case management and the definition of "targeted population." Three comments were received on this topic. Commenters asked for clarification of targeted case management and the definition of "targeted population."

Department response: Statements clarifying "targeted case management" and "targeted population" have been added to the chapter.

5. Person-centered planning. Nineteen comments were received on this topic.

• Eight comments requested changes to the wording used in subrule 90.4(1) regarding person-centered service plans and the person-centered planning process.

Department response: The Department has taken the comments under advisement, but has decided to not alter subrule 90.4(1) except as described in paragraph "6" below and except to add references to "guardian" to the subrule. The federal government has issued direction and guidance in relation to person-centered service plans and the person-centered planning process. The Department has purposefully chosen to not revise that wording other than to include a reference to "guardian" or "representative" wherever one term or the other is used.

• Five comments were received regarding the person-centered planning format or tool. Requests were made to have the formats and tools identified in rule.

Department response: The Department has taken the comments under advisement, but has decided to not make the suggested changes. The Department does not mandate or recommend any particular format or tool. If the case manager has options in either format or tool, then the member should have choice.

• One comment stated that the term "case manager" did not apply to IHH care coordination.

Department response: The definition of "case manager" in rule 441—90.1(249A) has been revised to explicitly include IHH care coordination for members participating in habilitation services and the children's mental health waiver.

• One comment requested the addition of the word "services" after any reference to HCBS.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule as suggested. "HCBS" is an acronym for "home- and community-based services." Adding the word "services" would be redundant.

• One comment requested that numbered paragraph 90.4(1)"b"(3)"10" be removed because the commenter thought that there was no identification of the entity responsible for carrying out the requirement stated in the paragraph.

Department response: The Department has taken the comment under advisement, but has decided to not remove or alter the paragraph. Paragraph 90.4(1)"b" already identifies the case manager as the person responsible for the person-centered service plan and processes.

• One comment asked the Department to designate the risk assessment tool to be used for all members.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rules as requested. The Department has purposefully chosen to allow each case management provider to choose the risk assessment tool to be used.

• One comment asked that a redundant mention of the 365-day cycle for service plan review and revision be removed.

Department response: The Department has taken the comment under advisement, but has decided to not alter the language. The Department has purposefully used redundant language to stress the importance of the time frame.

• One comment requested that the Department reinstate prior language regarding monitoring to use the word "may" instead of the word "shall."

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule relating to monitoring. The Department purposefully revised the rule to use "shall" because the Department expects case managers to review provider service documentation to ensure the member is receiving services as authorized.

6. Assessments. Thirteen comments were received on this topic.

• Three comments asked for clarification about the use of face-to-face or telephonic reassessments.

Department response: Subrule 90.4(1) has been revised to indicate that only a Supports Intensity Scale® (SIS) assessment can be done telephonically, and then only when the situation meets the criteria outlined by the American Association on Intellectual and Developmental Disabilities (AAIDD), and to state that an interRAI reassessment cannot be done telephonically.

• Three comments asked to add the reference for the core standardized assessment used for the habilitation population.

Department response: Clarifying statements have been added to the definition of "core standardized assessment" and to subrule 90.4(1).

• One comment stated that the term "comprehensive assessment" has not been defined in the rules.

Department response: The word "comprehensive" in relation to assessments has been removed from the rules.

• Two comments requested clarification of the statement that case managers may participate during the assessment or reassessment process at the request of the member.

Department response: Subrule 90.4(1) has been clarified in response to this request. The commenters seemed to believe that the participation of the case manager in the assessment allows the

case manager to become the assessor. This is not true. A trained assessor will always conduct the assessment. The case manager can participate just as a family member, representative, guardian, or provider can participate if chosen by the member.

• One commenter requested that the Department require that the case manager always be present unless contraindicated by the member.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule as suggested. While it is best practice that a case manager participates in the reassessment processes, the Department intends to allow member choice to take precedence.

• One commenter requested that the word "applicant" be used in conjunction with any mention of initial assessments, and that the word '"member" be used in conjunction with reassessments.

Department response: A definition of "applicant" has been added, and subrule 90.4(1) has been revised to refer to "applicant" as suggested, except in those parts of the subrule where federal guidance is used for the person-centered service plan and person-centered planning processes.

• One commenter suggested that the definition of "core standardized assessment" be moved out of the definitions rule and into the body of the rules.

Department response: The Department has taken the comment under advisement, but has decided to not alter the location of the definition.

• One commenter suggested that the Department require the assessment to be sent to the interdisciplinary team (IDT) within 14 calendar days.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule as suggested.

7. Covered services. Three comments were received on this topic.

• One comment questioned the change in subrule 90.4(1) to require monitoring activities by the case manager and stated that the words "as needed" appear to cause confusion.

Department response: The words "as needed" appeared in the proposed rules but have been removed upon revision. Monitoring is an integral part of case management and should be done as warranted by each individual situation. There are no frequency standards for this service.

• Two comments regarding case manager monitoring of provider documentation asked the Department to change the word "shall" to the word "may."

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule as suggested . The Department intends that case managers play a more active role in monitoring of provider documentation to gain better knowledge of the use of authorized services and of member welfare. At this time, the Department is not issuing guidance or mandates for this activity.

8. Billable activities. Two comments were received on this topic.

• One comment questioned the limited number of activities that are considered as billable activities for fee-for-service (FFS) case management (not applicable to MCO- or IHH-enrolled populations).

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule in response to the comment. Informational Letter 1394, effective July 1, 2014, announced the then new limited billable activities list. This list was the consensus of a case management workgroup whose intention was to standardize billable activities in order to bring about standardization of provider rates. Billable activities were purposefully limited in order to stress the importance of completing case management activities efficiently.

• One comment suggested that the Department annually adjust the FFS case management fee schedule to allow for wage and benefit increases.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule as suggested. The Iowa Legislature determines when FFS provider rates are changed. If the Legislature mandates an increase, then the Department will comply.

9. 441—Chapter 24. One comment was received on this topic.

• The commenter asked if a specific subrule of 441—Chapter 24 applied to IHH-enrolled providers.

Department response: This rule making is applicable to Medicaid case management. Any questions related to 441—Chapter 24 should be addressed directly to the mental health and disability services staff.

10. Service provider requirements. Four comments were received on this topic.

• One comment questioned whether the proposed changes to who must report incidents were adding in the types of staff responsible to report.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule in response to the comment. This rule making implements a requirement that has been in practice for years and is already included in the Department's other administrative rules.

• One comment expressed concern about the removal of references to appeal rights from the chapter.

Department response: The Department has taken the comment under advisement, but has decided to not alter the chapter in response to the comment. The Iowa Attorney General's office advised removal of references to appeal rights because those rights are addressed under the Department's other administrative rules. The intent is to avoid confusion due to the inclusion of these references in multiple rules. There is no effect on any member's appeal rights by the removal of these references in this chapter.

• Two comments were received in reference to use of a risk assessment and subsequent updates to the person-centered service plan based upon review of changes to the risk assessment. The commenter asked to have the updates made to a progress note or another place in the member record instead of in the service plan.

Department response: The Department has taken the comment under advisement, but has decided to not alter the rule as requested. A progress note is not the person-centered service plan; it is merely a record of activities. The service plan drives how services are provided and is the living document used to communicate the services, or changes to services, to all providers and the others responsible for the plan.

In addition to making the changes described above, the Department added four new items to update cross-references affected by the adoption of new Chapter 90. No other changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on January 8, 2020.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on March 18, 2020.

The following rule-making actions are adopted:

ITEM 1. Amend subrule 73.5(2) as follows:

73.5(2) *Community-based case management service.* The managed care organization is required to provide services that meet requirements specified in the contract and in ~~441—subrule 90.5(1)~~ 441—Chapter 90.

ITEM 2. Amend paragraph **78.27(6)"a"** as follows:

a. Scope. Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 3. Amend paragraph **78.37(17)"a"** as follows:

a. Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 4. Amend paragraph **78.43(1)"a"** as follows:

a. Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 5. Amend subparagraph **83.2(1)"d"(1)** as follows:

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in ~~rule 441—90.5(249A).~~ 441—paragraph 90.4(1)*"b."*

ITEM 6. Amend rule 441—83.7(249A), introductory paragraph, as follows:

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with ~~441—paragraph 90.5(1)*"b."*~~ 441—paragraph 90.4(1)*"b."* Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

ITEM 7. Amend paragraph **83.22(2)"a"** as follows:

a. Case management. Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 8. Rescind 441—Chapter 90 and adopt the following **new** chapter in lieu thereof:

CHAPTER 90
CASE MANAGEMENT SERVICES

PREAMBLE

Case management services are designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services. The term "case management" encompasses all categories of case management: targeted case management, case management and administrative case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the habilitation and children's mental health waiver populations. If a part of these rules does not apply to all categories of case management, then the rule will clarify the affected category(ies).

441—90.1(249A) Definitions.

"Adult" means a person 18 years of age or older on the first day of the month in which service begins.

"Applicant" means a person who has applied for an HCBS waiver or habilitation program.

"Care coordination" means the case management services provided by an integrated health home to members who are also receiving home- and community-based habilitation services pursuant to rule 441—78.27(249A) or HCBS children's mental health waiver services pursuant to rules 441—83.121(249A) through 441—83.129(249A).

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management

provided through managed care, and integrated health home (IHH) care coordination provided to the habilitation and children's mental health waiver populations.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled, including IHH care coordination.

"Child" means a person other than an adult.

"Chronic mental illness" means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found at rule 441—24.1(225C). For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Community-based case manager" means the employee of a Medicaid-contracted managed care organization (MCO) who provides case management services to MCO-enrolled members.

"Core standardized assessment" or *"CSA"* means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant's or member's needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs. The core standardized assessment shall be performed by a contractor under the direction of the department for the fee-for-service population. MCOs shall perform core standardized assessments for MCO-enrolled members or shall delegate the responsibility for completion of assessments. 441—Chapter 83 designates the assessment and reassessment tools to be used for each HCBS waiver. 441—Chapter 78 designates the assessment and reassessment tools to be used for habilitation.

"Department" means the department of human services.

"Developmental disability" means a severe, chronic disability that is determined through professionally administered screening and evaluations and that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care, (b) receptive and expressive language, (c) learning, (d) mobility, (e) self-direction, (f) capacity for independent living, and (g) economic self-sufficiency; and
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Fee-for-service member" or *"FFS member"* means a member who is not enrolled with a managed care organization because the member is exempt from managed care organization enrollment.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act.

"Integrated health home" or *"IHH"* means a provider of health home services that is a Medicaid-enrolled provider and that is determined through the provider enrollment process to have the qualifications, systems and infrastructure in place to provide IHH services pursuant to rule 441—77.47(249A). IHH covered services and member eligibility for IHH enrollment are also governed by rule 441—78.53(249A) and the health home state plan amendment. The IHH provides care coordination services for enrolled habilitation and children's mental health waiver members.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in rule 441—83.61(249A).

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the member;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F; or

6. Involves a member's location being unknown by provider staff who are responsible for protective oversight.

"Managed care organization" or *"MCO"* means the same as defined in rule 441—73.1(249A).

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 Code of Federal Regulations Section 435.1009. A residential care facility is not a medical institution.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that is not a major incident but that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

"Person-centered service plan" or *"service plan"* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or representative, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

"Targeted case management" means case management services furnished to assist members who are part of a targeted population.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or

2. A child who is eligible to receive HCBS intellectual disability waiver services or HCBS children's mental health waiver services according to 441—Chapter 83.

A member enrolled with a managed care organization or integrated health home is not part of the targeted population.

441—90.2(249A) Targeted case management. Rule 441—90.2(249A) applies only to the case management category of targeted case management and the defined targeted population.

90.2(1) *Eligibility for targeted case management.* A person who meets all of the following criteria shall be eligible for targeted case management:

a. The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35);

b. The person is a member of a targeted population;

c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);

d. The person has applied for targeted case management in accordance with the policies of the provider;

e. The person's need for targeted case management has been determined in accordance with rule 441—90.2(249A); and

f. The person is not eligible for, or enrolled in, Medicaid managed care.

90.2(2) *Determination of need for targeted case management.* Assessment at least every 365 days of the need for targeted case management is required as a condition of eligibility under the medical assistance program. The targeted case management provider shall determine the member's initial and ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member's file and shall demonstrate that all of the following criteria are met:

a. The member has a need for targeted case management to manage necessary medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member;

b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services; and

c. The member is not receiving, under the medical assistance program or under a Medicaid managed health care plan, other paid benefits that serve the same purpose as targeted case management or integrated health home care coordination.

90.2(3) *Application for targeted case management.* The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit or mental health and disability services regions if other services outside the scope of case management are needed or requested.

a. Application process and documentation. The application shall include the member's name, the nature of the request for services, and a summary of any evaluation activities completed. For FFS members, the provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management services agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

b. Application decision for targeted case management. The case manager shall inform the applicant, or the applicant's guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements at 441—subrule 7.7(1).

c. Denial of applications. The case manager shall deny an application for service when:

(1) The applicant is not currently eligible for Medicaid;

(2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);

(3) The applicant, or the applicant's guardian or representative, withdraws the application;

(4) The applicant does not provide information required to process the application;

(5) The applicant is receiving duplicative targeted case management or integrated health home care coordination from another Medicaid provider; or

(6) The applicant does not have a need for targeted case management.

90.2(4) *Transition to a community setting.* Managed care organizations must provide transition services to all enrolled members. Fee-for-service targeted case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management and is a member of a targeted population. Transitional case management is not an allowable service for other HCBS programs or populations;

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning;

c. The amount, duration, and scope of case management services shall be documented in the member's service plan, which must include case management services before and after discharge, to facilitate a successful transition to community living;

d. Payment shall be made only for services provided by Medicaid-enrolled targeted case management providers; and

e. Claims for reimbursement for case management services shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

441—90.3(249A) Termination of targeted case management services. Rule 441—90.3(249A) applies only to the case management category of targeted case management and the defined targeted population.

90.3(1) Targeted case management shall be terminated when:

a. The member does not meet eligibility criteria under rule 441—90.2(249A);

b. The member has achieved all goals and objectives of the service;

c. The member has no ongoing need for targeted case management;

d. The member is receiving targeted case management based on eligibility under an HCBS program but is no longer eligible for the program;

e. The member or the member's guardian or representative requests termination;

f. The member is unwilling or unable to accept further services; or

g. The member or the member's guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of targeted case management.

90.3(2) The provider shall notify the member or the member's guardian or representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

441—90.4(249A) Case management services. Rule 441—90.4(249A) applies to all categories of case management and all populations covered by case management.

90.4(1) *Covered services.* The following shall be included in case management services provided to members, whether FFS members or MCO-enrolled members:

a. Assessment. Initial assessments and regular reassessments must be done for each applicant and member to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. The assessments and reassessments shall address all of the applicant's and member's areas of need, strengths, preferences, and risk factors, considering the person's physical and social environment. Applicants and members will receive individualized prior notification of the assessment tool to be used and of who will conduct the assessment. The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each waiver population and 441—Chapter 78 for the habilitation population. Initial assessments must be face to face. Reassessments using the interRAI must be done face to face. Only the Supports Intensity Scale® assessment can be done telephonically, and then only when the situation meets the criteria outlined by the American Association on Intellectual and Developmental Disabilities (AAIDD). The off-year assessment (OYA) for the intellectual disability waiver can be done telephonically. A reassessment must be conducted at a minimum every 365 days and more frequently if material changes occur in the member's condition or circumstances. Case managers may participate during the assessment or reassessment process at the request of the applicant or member; the case manager does not assume the role of the assessor.

b. Person-centered service plan. At least every 365 days, the case manager shall develop and revise a comprehensive, person-centered service plan in collaboration with the member, the member's service providers, and other people identified as necessary by the member, as practicable. The person-centered service plan will be developed based on the assessment and shall include a crisis intervention plan based on the risk factors identified in a risk assessment. The case manager shall document the member's history, including current and past information and social history, and shall update the history annually. The case manager shall gather information from other sources such as family members, medical providers, social workers, guardians, representatives, and others as necessary to form a thorough social history and comprehensive person-centered service plan with the member. The person-centered service plan may also be referred to as a person-centered treatment plan.

(1) The person-centered service plan shall address all service plan components outlined in this chapter and in 441—Chapter 83 for the waiver in which the member is enrolled or 441—Chapter 78 for members enrolled in habilitation.

(2) Person-centered planning shall be implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. In order for this to occur, there are certain process elements that must be included in the process. These include:

1. The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary.

2. The process is timely and occurs at times and locations of convenience to the member, the member's guardian or representative and family members, and others, as practicable.

3. Necessary information and support are provided to ensure that the member or the member's guardian or representative is central to the process and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process.

5. The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs.

6. The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services.

7. The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

8. Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns.

9. There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

10. Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals.

11. The member or the member's guardian or representative shall be central in determining what available HCBS are appropriate and will be used.

12. The member shall be able to choose between providers or provider entities, including the option of self-directed services when available.

13. The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety.

14. The planning process should not be constrained by any case manager's or guardian's or representative's preconceived limits on the member's ability to make choices.

15. Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives.

(3) Elements of the person-centered service plan. The person-centered service plan shall identify the services and supports that are necessary to meet the member's identified needs, preferences, and quality of life goals. The person-centered service plan shall:

1. Reflect that the setting where the member resides is chosen by the member. The chosen setting must be integrated in, and support full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. Be prepared in person-first singular language and be understandable by the member or the member's guardian or representative.

3. Note the strengths-based positive attributes of the member at the beginning of the plan.

4. Identify risks, while considering the member's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Document goals in the words of the member or the member's guardian or representative, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality of life concepts important to the member.

6. Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan.

7. Document the specific person or persons, provider agency and other entities providing services and supports.

8. Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.

9. Document non-paid supports and items needed to achieve the goals.

10. Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's guardians or representatives, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles.

11. Identify each person and entity responsible for monitoring the plan's implementation.

12. Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of the member.

13. Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff).

14. Address elements of self-direction through the consumer choices option (e.g., financial management service, support broker/agent, alternative services) whenever the consumer choices option is chosen.

15. Be distributed directly to all parties involved in the planning process.

c. Referral and related activities. The case manager shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan.

d. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home, when applicable), and all services regardless of the service funding stream. Monitoring shall also include review of service provider documentation. Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted:

(1) Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service;

(2) The member has declined services in the service plan;

(3) Communication among providers is occurring, as practicable, to ensure coordination of services;

(4) Services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and

(5) There are changes in the needs or circumstances of the member. Follow-up activities shall include making necessary adjustments in the person-centered service plan and service arrangements with providers.

e. Contacts. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements:

(1) The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly;

(2) The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face to face or by telephone;

(3) Community-based case management contacts will be made in accordance with the Medicaid contract MED-16-019, or subsequent Medicaid managed care contracts with the department, in those instances where the contract specifies contacts different from this rule.

90.4(2) *Exclusions.* Payment shall not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs;

(2) Public guardianship programs;

(3) Special education programs;

(4) Child welfare and child protective services; or

(5) Foster care programs.

c. The activities are components of the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program;

(2) Assessing adoption placements;

(3) Recruiting or interviewing potential foster care parents;

(4) Serving legal papers;

(5) Conducting home investigations;

(6) Providing transportation related to the administration of foster care;

(7) Administering foster care subsidies; or

(8) Making placement arrangements.

d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

441—90.5(249A) Rights restrictions. Rule 441—90.5(249A) applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member to realize the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. The following requirements must be documented in the plan when a safety need has been identified that warrants a rights restriction:

1. The specific and individualized assessed safety need;

2. The positive interventions and supports used prior to any modifications or additions to the person-centered service plan regarding safety needs;

3. The less intrusive methods of meeting the safety needs that have been tried but were not successful;

4. A clear description of the rights restriction that is directly proportionate to the specific assessed safety need;

5. The regular collection and review of data to measure the ongoing effectiveness of the rights restriction;

6. The established time limits for periodic reviews to determine whether the rights restriction is still necessary or can be terminated;

7. The informed consent of the member to the proposed rights restriction; and

8. An assurance that the rights restriction itself will not cause undue harm to the member.

441—90.6(249A) Documentation and billing.

90.6(1) *Documentation of contacts.* Subrule 90.6(1) applies to all categories of case management and all populations covered by case management.

a. Documentation of case management services contacts shall include:

(1) The name of the individual case manager;

(2) The need for, and occurrences of, coordination with other case managers within the same agency or referral or transition to another case management agency; and

(3) Other requirements as outlined in rule 441—79.3(249A) to support payment of services.

b. Targeted case management providers serving FFS members must also adhere to 441—subrule 24.4(4).

90.6(2) *Rounding units of service for case management services.* Subrule 90.6(2) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. For all fee-for-service case management units of service, the following rounding process shall be used:

a. Add together the minutes spent on all billable activities during a calendar day for a daily total;

b. For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day;

c. Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit; and

d. Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

90.6(3) *Collateral contacts.* Subrule 90.6(3) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. For all fee-for-service case management units of service, the case manager may bill for documented contacts with other entities and individuals if the contacts are directly related to the member's needs and care, such as helping the member access services, identifying needs and supports to assist the member in obtaining services, providing other case managers with useful feedback, and alerting other case managers to changes in the member's needs.

90.6(4) *Billable activities for case management services.* Subrule 90.6(4) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. Billable activities for case management services are limited to the following activities, and any activity included in this list must be billed if the activity has occurred.

a. Face-to-face meeting with the member:

(1) Contact time; and

(2) Documentation completed during meeting.

b. Telephone conversation with the member:

(1) Contact time; and

(2) Documentation completed during meeting.

c. Collateral contacts on behalf of the member, including face-to-face, telephone, and email contacts:

(1) Contact time; and

(2) Documentation completed during meeting.

d. Individual care plans and person-centered service plans:

(1) Creation; and

(2) Revision.

e. Social histories:

(1) Creation; and

(2) Revision.

f. Assessments and reassessments:

(1) Participation during the assessment if requested by the member; and

(2) Utilization of the assessment for creation of the person-centered service plan.

441—90.7(249A) Case management services provider requirements. Rule 441—90.7(249A) applies to all categories of case management and all populations covered by case management.

90.7(1) *Reporting procedures for major incidents.*

a. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member shall notify the following persons of the incident by midnight of the next calendar day after the incident:

1. The staff member's supervisor;
2. The member or member's legal guardians; and
3. The member's case manager. The case manager shall create an incident report if a provider has not submitted a report.

(2) By midnight of the next business day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known by the staff member about the incident to the member's managed care organization in the format required by the managed care organization. If the member is not enrolled with a managed care organization, or is receiving money follows the person funding, the staff member shall report the information by direct data entry into the Iowa Medicaid portal access (IMPA) system. The case manager is responsible for reporting the incident if the provider of service has not already reported the incident.

(3) The following information shall be reported:

1. The name of the member involved;
2. The date, time, and location where the incident occurred;
3. A description of the incident;
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other Medicaid-eligible members or non-Medicaid-eligible persons who were present must be maintained by the use of initials or other means;
5. The action taken to manage or respond to the incident;
6. The resolution of or follow-up to the incident; and
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) When complete information about the incident is not available at the time of the initial report, the case management services provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up.

(5) The case management services provider shall maintain the completed report in a centralized file with a notation in the member's file.

(6) The case management services provider shall track incident data and analyze trends to assess the health and safety of members served and to determine whether changes need to be made for service implementation or whether staff training is needed to reduce the number or severity of incidents.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation to ensure that the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the service plan in order to ensure the continued health, safety, and welfare of the member. Documentation must be made in the person-centered service plan of this review and follow-up activities.

90.7(2) *Reporting procedures for minor incidents.* Minor incidents may be reported in any format designated by the case management services provider. When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

90.7(3) *Quality assurance.* Case management services providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise or a Medicaid managed care

organization, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

a. Postpayment review of case management services;

b. Review of incident reports;

c. Review of reports of abuse or neglect; and

d. Technical assistance in determining the need for service.

These rules are intended to implement Iowa Code section 249A.4.

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